Pain Management Consortium of Ohio, Inc.
Bruce Massau, D.O., E.M.B.A.
Amy Kirk, CNP
393 East Town Street, Suite 109
Columbus OH 43215
Phone: (614) 252-1500 FAX: (614) 252-1685

NAME: _____ **DATE:** _____

You Must fill this form out completely using blue or black ink in order to receive prescriptions.

REFILLS NEEDED FROM OUR OFFICE TODAY.

MEDICATION NAME	DOSE (mg)	DIRECTIONS

QUESTIONS FOR THE DOCTOR AT TODAY'S VISIT: _____

_____

TODAY'S VISIT

What is the reason for today's visit? (Please circle **all** that apply): Post-Procedure Assessment/Wound Check
New Problem Medication Refill Review Imaging Other: _____

Which provider will you be seeing today? _____

SINCE YOUR LAST VISIT

Is your pain better, worse or the same? (Circle One) Better Worse The Same

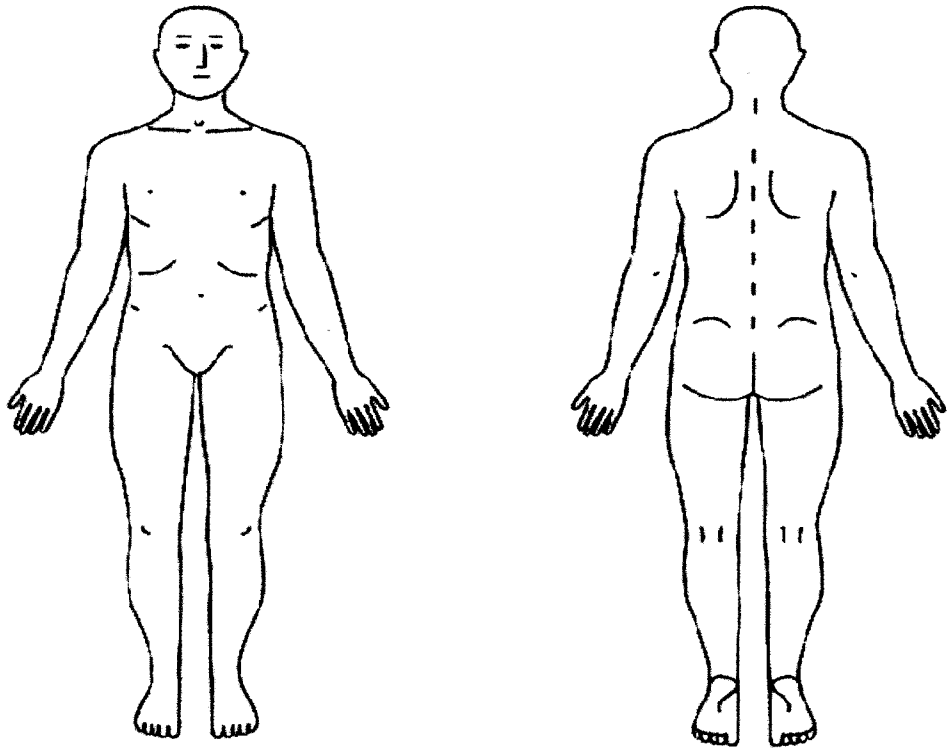
Do you have any **NEW** Concerns? ☐ NO ☐ YES Please List: _____
Any **NEW** medical problems or surgeries? ☐ NO ☐ YES Please List: _____
Any **NEW** medication side effects? ☐ NO ☐ YES Please List: _____
Are you on any **NEW** medications? ☐ NO ☐ YES Please List: _____
Any **NEW** imaging studies or lab work? ☐ NO ☐ YES Please List: _____
Do you have **ANY** allergies? ☐ NO ☐ YES Please List: _____
Are you seeing any **NEW** providers/Doctors? ☐ NO ☐ YES Please List: _____
Are you on **ANY** blood thinners? ☐ NO ☐ YES Please List: _____
When was your last bowel movement? _____

Please turn over and complete side 2

Name:_____ Date:_____

Please use the following symbols to fill in the diagram below:

N	Numbness	+	Sharp	*	Burning
Δ	Aching	//	Pins/Needles	√	Shooting
o	Other (describe)				



Circle a number from 0 (no pain) to 10 (worst pain imaginable):

What is your current pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

What is your average pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

Since your LAST VISIT at this office, have you suffered from any of the following?

☐ new numbness	☐ new weakness	☐ new pain	☐ dizziness
☐ diarrhea	☐ nervousness	☐ anxiety	☐ insomnia
☐ confusion	☐ tremors	☐ memory lapse	☐ flushing
☐ itching	☐ bladder problems	☐ lightheaded	☐ fatigue
☐ drowsiness	☐ double vision	☐ blurred vision	☐ constipation
☐ excessive sweating	☐ dry mouth	☐ swelling	☐ hallucinations
☐ headaches	☐ jerkiness	☐ nausea/vomiting	☐ recreational drug use
☐ breathing difficulty	☐ sleepiness/sedation	☐	☐

Please explain any new/unusual symptoms you noted:

_____

_____

_____